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Learning the Language of Another: How Training in Religion Prepared Me to be a Public Health Practitioner

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Editors' Note: The PHRS Bulletin *regularly features accounts and reflections from early career professionals in public health about their discovery, training, knowledge, work, and reflections upon spiritual and religious factors in public health.*

Like many, my interest in religion, spirituality, and public health emerged from lived experience. As I look back, I can now see how I observed these dynamics in action long before I began my training in public health. For example, while on a church mission trip to Guatemala during my undergraduate career – an experience I look back on now with mixed assessment – I witnessed how much care and how many support services were provided to children orphaned by HIV/AIDS from a group of local, dedicated nuns. Religion was doing a good thing; it was motivating individuals to care for children who needed to be cared for in their community.

While in Uganda for study abroad a year and a half later, a local organization working to care for people living with HIV/AIDS explained to me that when doctors or clinics advertised health clinics, very few people would attend. However, when local faith leaders advertised the same events, most of the community attended. During this trip, I began to understand religion as both a personal and individual experience as well as a social influence with meaningful impacts on our health.

As I set out for my graduate public health education, I was immediately drawn to the Religion and Health collaborative opportunities at Emory University, specifically the Religion and Health Certificate. Learning from faculty at the Rollins School of Public Health and from faculty at the Candler School of Theology was an unparalleled opportunity for me. Completing the Religion and Health Certificate required a mix of theoretical and stage-setting courses, as well as practice-based courses like developing faith-based funding proposals to improve health, reviewing case studies from global contexts, and holding mock debates about some of the most pressing issues related to religion and sexual health.

The most important thing I learned from both the theoretical and applied courses was that I was learning a language that my other public health peers were not. I began to notice that theology and public health students were starting to understand each other in new ways and were able to communicate using shared language and mutual respect. This bridge building happened quietly and slowly through my courses. Simultaneously, I started to notice the ways in which my public health peers without this training approached not only religion, but other moral frameworks not rooted in western biomedicine too. While my peers were and are incredibly thoughtful, many talked about religion and faith systems as things that needed correction, viewing people of faith as those who only believed and practiced because of a lack of knowledge. Once I noticed these things, I couldn't unsee them – and moreover, I saw that the broader field of public health also holds these biases. I reached a point where I questioned if I should even be pursuing public health. Luckily, I had Mimi Kiser and John Blevins as mentors who had been working in this intersection and encouraged me to stick with the 'messiness' in which I was finding myself.

I'm glad I stuck with it, because having training in religion gave me a better understanding of the social determinants of health. My time with Emory and the Interfaith Health Program taught me to step back and view socio-contextual factors as interconnected and powerful to both positively and negatively impact our health. This curriculum also bolstered my systems-level thinking, allowing me to be a well-rounded public health practitioner. There have been concrete, tangible, and explicit skills that benefit me in public health as a result of this training: my training is rich in teamwork with people who think, see, and act differently than I do; I have been able to practice hard conversations with no apparent or easy solutions; I have a strong ability to identify common ground for effective partnership building; and I am equipped to engage faith communities or faith-based organizations because I recognize their language. There are many additional skills that can be thought of as less concrete and not as tangible, but equally important. My training fostered a deep respect for different world views, which has allowed me to really build muscles for empathy; I am able to serve as a "traffic stop" in public health settings to ensure public health action is equitable and avoids paternalistic assumptions on the basis of religion.

These skills have benefitted me in my current position in homelessness and health, which very rarely has black and white answers. I do not shy away from the complicated and messy borders of public health and housing services; I lean into the gray space and feel comfortable navigating it. In partnerships between public health and housing services, I am able to come to the table and say, "I'm listening, and I want to find ways we can value each other's needs and goals at the same time."

While supporting an emergency intake shelter for refugees during COVID-19, I had an "aha" moment where all of my courses and practical experiences set me up for success and I realized how important this intersection was. There was a local faith group that wanted to hold religious services at the shelter during an important time of religious observation for their faith tradition. It was clear that those staying at the shelter were wanting and needing spiritual rest and care, but many agencies and organizations working on site couldn't see how this would be possible given the need for COVID-19 prevention measures like masks and distancing. Other staff were fully expecting the public health team to reject the idea immediately. Instead, two logistics coordinators and I met with local faith leaders to discuss the rituals performed on these holidays, their importance, and how they could be practiced in modified ways to minimize potential disease transmission without sacrificing what constitutes faithful action. We practiced walk-throughs and trained their volunteers on proper PPE usage and the modified practices. The celebration of the holiday was beautiful and immediately lifted spirits of everyone on site. While there are many who could have done the same thing, I truly believe my training at this intersection prepared me to make that situation the best it could be, marked by a deep respect and love for one another.

Through personal experience and my training in religion and health, I know how important religion can be at an individual level. I know what it feels like to weigh decisions of present, earthly gratification with the promise of eternal salvation and freedom. I can empathize with people who hold value and seek guidance from both the physical world and the meta-physical world. This inspires and requires me to be flexible in public health. Working at the intersection of religion and health necessitates creative communication and bridge building, which are critical building blocks to effective public health. I would not be the public health practitioner I am today if it weren't for my training at the intersection of religion and health.

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